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## INSTRUCTIONS

TO AVOIDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be signed within 24 hours after death. The burial copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M-

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## CERTIFICATE OF DEATH

00693

Reg. Dist. No. ....

697

1. PLACE OF DEATH COUNTY <b>GARRETT</b> CITY (If outside corporate limits, write RURAL OR and give nearest town) <b>OKLAND</b> TOWN HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>EVANS NURSING HOME</b>				2. USUAL RESIDENCE (HOME) OF DECEASED STATE <b>W.VA.</b> COUNTY <b>GRANT</b> CITY (If outside corporate limits, write RURAL and give nearest town) <b>RURAL- HARTMANVILLE</b> TOWN STREET ADDRESS (If rural give location) <b>MT. PISGAH ROAD</b>			
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <b>JAMES R. RAPHAEL BAKER</b>				4. DATE OF DEATH (Month) (Day) (Year) <b>JAN. 19, 1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>WIDOWED</b>	8. DATE OF BIRTH <b>AUG. 13, 1879</b>	9. AGE last birthday <b>78</b> yrs.	10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, or retired) <b>Retired Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>OWN FARM</b>		11. BIRTHPLACE (State or foreign country) <b>Grant Co., W.Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>WILLIAM B. BAKER</b>				14. MOTHER'S MAIDEN NAME <b>NAOMI KITZMILLER</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or unk.) (If Yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT & ADDRESS <b>VICTOR W. KITSMILLER, SHAW, W.Va.</b>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <b>Acute Myocardial Infarction</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSE(S) DUE TO (B) <b>Cerebral hemorrhage with right</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <b>subcl. paralysis</b>						<b>2 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>Hypertension</b>						<b>2 yrs</b>	
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 19, 1955</u> , to <u>Jan 19, 1958</u> , that I last saw the deceased alive on <u>Jan 19, 1958</u> , and that death occurred at <u>3:20 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <b>Ralph Calabrese</b>				ADDRESS (Street, city, town, state) <b>Kitzmiller, Md</b>		DATE SIGNED <b>Jan 20 - 58</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>1/22/58</b>		NAME OF CEMETERY OR CREMATORY <b>Evans Cemetery</b>		LOCATION (City, town, or county) (State) <b>Hartmansville, Grant Co.</b>	
24. REC'D BY REGISTRAR DATE <b>JAN 22 '58</b>		REGISTRAR'S SIGNATURE <b>Overland</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>A. Shopless</b>		ADDRESS W.Va. <b>Blaine, W.Va</b>	

CERTIFICATE OF DEATH

Form 100-10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF CORONER

11. SIGNATURE OF BURIAL OFFICIAL

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF DEPUTY SHERIFF

17. SIGNATURE OF CLERK OF COURT

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF DEPUTY SHERIFF

22. SIGNATURE OF CLERK OF COURT

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF DEPUTY SHERIFF

27. SIGNATURE OF CLERK OF COURT

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

32. SIGNATURE OF CLERK OF COURT

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

35. SIGNATURE OF SHERIFF

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF DEATH

5. PLACE OF DEATH

6. CAUSE OF DEATH

7. MANNER OF DEATH

8. SIGNATURE OF PHYSICIAN

9. SIGNATURE OF WITNESSES

10. SIGNATURE OF CORONER

11. SIGNATURE OF BURIAL OFFICIAL

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF DEPUTY SHERIFF

17. SIGNATURE OF CLERK OF COURT

18. SIGNATURE OF JURY

19. SIGNATURE OF JUDGE

20. SIGNATURE OF SHERIFF

21. SIGNATURE OF DEPUTY SHERIFF

22. SIGNATURE OF CLERK OF COURT

23. SIGNATURE OF JURY

24. SIGNATURE OF JUDGE

25. SIGNATURE OF SHERIFF

26. SIGNATURE OF DEPUTY SHERIFF

27. SIGNATURE OF CLERK OF COURT

28. SIGNATURE OF JURY

29. SIGNATURE OF JUDGE

30. SIGNATURE OF SHERIFF

31. SIGNATURE OF DEPUTY SHERIFF

32. SIGNATURE OF CLERK OF COURT

33. SIGNATURE OF JURY

34. SIGNATURE OF JUDGE

BUREAU V. S.

JAN 22 1953

RECEIVED

698

## CERTIFICATE OF DEATH

Reg. Dist. No.

00694

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>x Oakland,</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS <b>/</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>James Bernard Bell, Sr.</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 13, 1888</b>
9. AGE (In years last birthday) <b>69</b> yrs.		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Taking pictures</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Lloyd D. Bell</b>		14. MOTHER'S MAIDEN NAME <b>Mary E. Heslen</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-32-3078</b>	
17. INFORMANT <b>Mrs. James Bell</b>		Address <b>Oakland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion Acute</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic Cardiovascular Disease 10 years</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I attended the deceased from <b>Jan 9</b> , 19 <b>58</b> , to <b>Jan 9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>Jan 9</b> , 19 <b>58</b> , and that death occurred at <b>11:30 P. M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St. Oakland, Md.</b>	
DATE SIGNED <b>Jan 19 1958</b>			
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton, M. D.</b>		<b>77 Oak Street, Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 12, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oakland</b>		22d. LOCATION (City, town, or county) (State) <b>Oakland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. ...</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 6 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

JAN 15 1973

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

699

## CERTIFICATE OF DEATH

Reg. Dist. No.

00695

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		MARYLAND c. LENGTH OF STAY IN 1b <b>68</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Alder St.</b>		d. STREET ADDRESS <b>Alder St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																	
3. NAME OF DECEASED (Type or print) First <b>Prima</b> Middle <b>Maria</b> Last <b>Brown</b>		4. DATE OF DEATH Month <b>Jan.</b> Day <b>15</b> Year <b>1958</b>		5. SEX <b>Female</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>6/4/89</b>		9. AGE (In years last birthday) <b>68</b> yrs.		IF UNDER 1 YEAR Months <b>68</b> Days <b>15</b> Hours <b>1958</b> Min.													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>		11. BIRTHPLACE (State or foreign country) <b>Oakland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>		13. FATHER'S NAME <b>DeCorsey E. Bol den</b>		14. MOTHER'S MAIDEN NAME <b>Sarah J. Roth</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mary E. Bolden, Oakland, Md.</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary occlusion</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary heart disease</b> DUE TO (c) <b>Hypertensive C.V.D.</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b> <b>3 years</b> <b>10 years</b>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>no</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Oakland</b>		20f. (City or town) <b>Garrett</b>		(County) <b>Md.</b>		(State)					
21. I certify that I attended the deceased from _____, 1939, to 15 Jan, 1958, that I last saw the deceased alive on 14 Jan, 1958, and that death occurred at 6:30 AM, from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>Oakland Md.</b>		DATE SIGNED <b>15 Jan 58</b>		ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		PHYSICIAN'S NAME (Type) <b>Andrew E. Mance</b>		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1/17/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oakland Cemetary</b>		22d. LOCATION (City, town, or county) <b>Oakland</b>		(State) <b>Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>William</b>		ADDRESS <b>Oakland, Md.</b>		24a. REC'D BY REGISTRAR <b>JAN 22 '58</b>		24b. REGISTRAR'S SIGNATURE <b>William</b>	

TAN 22 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 3 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00696

700

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X OAKLAND MD</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EVANS NURSING HOME</b>		d. STREET ADDRESS <b>1</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>LAWRENCE MILTON FRALEY</b>		4. DATE OF DEATH Month Day Year <b>JAN. 27 1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH-20-1892</b>
9. AGE (In years last birthday) <b>65 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED BEVERAGE DEALER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>TERRA ALTA W.VA</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE A. FRALEY</b>		14. MOTHER'S MAIDEN NAME <b>EVALYN SHAWEN.</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>217-28-0165</b>	
17. INFORMANT <b>MRS. EDITH FRALEY</b> Address <b>OAKLAND MD</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident (Epistaxis) mor + 2 years</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease 10 years</b> DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260X Diabetes Mellitus</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February, 1957</b> , to <b>January, 1958</b> , that I last saw the deceased alive on <b>January 24, 1958</b> , and that death occurred at <b>7:55 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert H. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak Street Oakland, Md</b> DATE SIGNED <b>1/29/58</b>	
PHYSICIAN'S NAME (Type) <b>Herbert H. Leighton</b>		<b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>JAN-30-1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAKLAND CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>OAKLAND MD</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Balden Foreign Home</b> ADDRESS <b>Oakland Md.</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 3 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Dr. Leighton</b>			

BUREAU V. S.

1958

RECEIVED



701  
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN IB <b>38 HOURS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>FRIEND</b> Last <b>FRIEND</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-9-1884 -1884</b>	9. AGE (In years last birthday) <b>73</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TIMBER WORKER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>LUMBER</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOAB FRIEND</b>			14. MOTHER'S MAIDEN NAME <b>JANETTE FRIEND</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-12-9639</b>		17. INFORMANT <b>CLARENCE McCOMBIE, FRIENDSVILLE, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.2</b> DUE TO <b>Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Myocardial Heart Disease &amp; Pulmonary</b> DUE TO <b>Fracture &amp; Chronic Failure</b> (c) <b>4 years</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>4 years</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>6-14</b> , 19 <b>56</b> , to <b>1-13</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-12</b> , 19 <b>58</b> , and that death occurred at <b>6:05 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.				ADDRESS (Street, city or town, state) <b>Oakland Md</b>		DATE SIGNED <b>13 Jan 58</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.</b>				<b>OAKLAND, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>1-16-1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Blooming Rose Cmr. Friendsville, Md</b>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. H. Redakauer - Martlettsburg Pa.</b>				24a. REC'D BY REGISTRAR <b>Jan 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Redakauer</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Reg. No. 100

1. NAME OF DECEASED <b>JOHN J. BROWN</b>		2. SEX <b>MALE</b>	
3. DATE OF BIRTH <b>1895</b>		4. PLACE OF BIRTH <b>NEW YORK</b>	
5. OCCUPATION <b>LABORER</b>		6. CAUSE OF DEATH <b>HEART DISEASE</b>	
7. DATE OF DEATH <b>1958</b>		8. PLACE OF DEATH <b>HOME</b>	
9. SIGNATURE OF DECEASED <b>[Signature]</b>		10. SIGNATURE OF WITNESS <b>[Signature]</b>	
11. SIGNATURE OF PHYSICIAN <b>[Signature]</b>		12. SIGNATURE OF CORONER <b>[Signature]</b>	
13. SIGNATURE OF JURY <b>[Signature]</b>		14. SIGNATURE OF JUDGE <b>[Signature]</b>	
15. SIGNATURE OF CLERK <b>[Signature]</b>		16. SIGNATURE OF REGISTRAR <b>[Signature]</b>	
17. SIGNATURE OF NOTARY <b>[Signature]</b>		18. SIGNATURE OF SHERIFF <b>[Signature]</b>	
19. SIGNATURE OF JAILER <b>[Signature]</b>		20. SIGNATURE OF PRISONER <b>[Signature]</b>	
21. SIGNATURE OF DECEASED'S NEAREST RELATIVE <b>[Signature]</b>		22. SIGNATURE OF DECEASED'S NEXT OF KIN <b>[Signature]</b>	
23. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		24. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
25. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		26. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
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33. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		34. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
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61. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		62. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
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81. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		82. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
83. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		84. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
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89. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		90. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
91. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		92. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
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95. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		96. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
97. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		98. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	
99. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>		100. SIGNATURE OF DECEASED'S ESTATE <b>[Signature]</b>	

BUREAU V. S.

IAN 20 1958

RECEIVED

# CERTIFICATE OF DEATH

00698

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland, Md.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Beryl, West Virginia</b> <b>85 x 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>Beryl, West Virginia</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Gaskey</b> Last <b>Gaskey</b>		4. DATE OF DEATH Month <b>January</b> Day <b>26</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/20/80</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months <b>78</b> Days <b>78</b> Hours <b>78</b> Min. <b>78</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Poland</b>	
11. BIRTHPLACE (State or foreign country) <b>Poland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America, U.S.A.</b>	
13. FATHER'S NAME <b>Gaskey, Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Not Known</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>235-52-5138</b>	
17. INFORMANT <b>John Gaskey Jr.</b>		Address <b>Piedmont, West Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>904.0 Anthracosis, silicosis, pneumonia</b> DUE TO (b) <b>fracture of ribs and scapula</b> DUE TO (c) <b>lying cause lost.</b> INTERVAL BETWEEN ONSET AND DEATH <b>Approx 5 days</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>Fell hurting back and chest.</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <b>1-21-1958</b> <b>20d. INJURY OCCURRED</b> While <input checked="" type="checkbox"/> at work Nat while <input type="checkbox"/> at work <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>20f. (City or town)</b> <b>Beryl</b> (County) <b>W. Va.</b> (State) <b>W. Va.</b>			
21. I certify that I attended the deceased from <b>1-21-1958</b> to <b>1-26-1958</b> , that I last saw the deceased olive on <b>1-26-1958</b> , and that death occurred at <b>8:03 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland, Maryland</b> DATE SIGNED <b>Dr. Joseph Alvarez</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b> 22b. DATE THEREOF <b>1/29/58</b> 22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter's</b> 22d. LOCATION (City, town, or county) (State) <b>Westernport Md</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>St. Peter's Westernport, Md.</b>		24a. REC'D BY REGISTRAR <b>DATE JAN 31 '58</b> 24b. REGISTRAR'S SIGNATURE <b>Alvarez</b>	

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS  
OFFICE OF THE REGISTRAR  
ALBANY, N. Y.

CERTIFICATE OF DEATH

BUREAU V. B.

Jan 31 1958

RECEIVED

## CERTIFICATE OF DEATH

Reg. Dist. No.

00699

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. VA.</b> b. COUNTY <b>GRANT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. LENGTH OF STAY IN lb <b>31 HOURS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JACK</b> Middle <b>WAYNE</b> Last <b>GUTHRIE</b>		4. DATE OF DEATH Month <b>1</b> Day <b>16</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/23/1927</b>
9. AGE (In years last birthday) <b>30</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>16</b> Hours <b>31</b> Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>OILER</b>		11b. KIND OF BUSINESS OR INDUSTRY <b>INDUSTRY</b>	
11c. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GUTHRIE, EARLY CLINTON</b>		14. MOTHER'S MAIDEN NAME <b>SEYMOUR, BESSIE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)	
17. INFORMANT <b>HILDA DEL SIGNORE</b>		Address <b>RT. #1, GORMANIA, W.VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of C5 with complete cervical cord transection</b> DUE TO (b) _____ DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>fell from a shovel beam.</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>7:00</b> p. m. <b>Jan. 14 1958</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Coal strip mine</b>		20f. (City or town) (County) (State) <b>Bayard Grant, W. Va.</b>	
21. I certify that I attended the deceased from <b>Jan. 14 1958</b> to <b>Jan. 16 1958</b> , that I last saw the deceased alive on <b>Jan. 16 1958</b> , and that death occurred at <b>5:20 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Joseph Alvarez</b>		ADDRESS (Street, city or town, state) <b>Oakland, Md.</b>	
PHYSICIAN'S NAME (Type) <b>Joseph Alvarez</b>		DATE SIGNED <b>1/16/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-18-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bayard Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Bayard Grant, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Heaton</b>		ADDRESS <b>Terra Alta W. Va.</b>	
24a. REGISTRY SIGNATURE <b>GARY</b>		24b. REGISTRY SIGNATURE <b>GARY</b>	
DATE <b>1/16/58</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

STATE OF MARYLAND

COUNTY OF BALTIMORE

CITY OF BALTIMORE

WITNESSES

DECEASED

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF ENTRY

PLACE OF ENTRY

BUREAU V. 1

JAN 22 1958

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00700

704

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>EL K GARDEN</b> <b>85 x - 3</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>SHADYSIDE</b>	
3. NAME OF DECEASED (Type or print) First <b>BABY</b> Middle <b>GIRL</b> Last <b>HARTMAN</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>22</b> Year <b>19 58</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JANUARY 22, 1958</b>
9. AGE (In years last birthday) yrs. <b>1</b>		IF UNDER 1 YEAR Months Days Hours Min. <b>1 20</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>LEE ALLEN HARTMAN</b>		14. MOTHER'S MAIDEN NAME <b>STONEBREAKER, MARY CATHERINE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>LEE ALLEN HARTMAN, ELK GARDEN, W. VA.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Anoxia</b> <b>761.5</b> DUE TO <b>(Baby Born Alive By Cesarean Section)</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7 1/2 mos gestation. Placenta previa</b> DUE TO <b>(Hemorrhage - Thrombosis)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>7 1/2 mos Preg.</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 hr 30 min</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>JAN. 22, 19 58</b> , to <b>JAN. 22, 19 58</b> , that I last saw the deceased alive on <b>JAN. 22, 19 58</b> , and that death occurred at <b>2:30 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Oakland, W. Va.</b> DATE SIGNED <b>1. 22. 58</b> ACTUAL SIGNATURE <b>James H. Feaster, Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>JAMES H. FEASTER, JR., M.D.</b> <b>OAKLAND, MARYLAND</b>			
22a. BURIAL, CREMATION, 22b. DATE THEREOF BURIAL (Specify) <b>1.25.58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>KALBAUGH CEMETERY</b>	
22d. LOCATION (City, town, or county) (State) <b>ELK GARDEN, MINERAL CO., W. VA.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>O. H. Sharpless, Blaine, W. VA.</b>	
24a. REC'D BY REGISTRAR <b>JAN 27 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Dee Smith</b>	

2270347XVI

# CERTIFICATE OF DEATH

MAXLAND STATE DEPARTMENT OF HEALTH—SACRAMENTO 10

BUREAU V. S.

1 JAN 27 1938

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

00701

705

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND RURAL</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		/ d. STREET ADDRESS <b>STAR ROUTE, BOX # 52</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>CARLIS</b> Middle <b>BURTON</b> Last <b>HELMS</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>10</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCT. 3, 1915</b>
9. AGE (In years last birthday) <b>42</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>truck driver</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COUNTY ROADS DEPT.</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RANDOLPH HELMS</b>		14. MOTHER'S MAIDEN NAME <b>VERNA SINES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-16-2533</b>	
17. INFORMANT <b>Mrs. Hazel Sarah Helms</b>		Address <b>Star Rt., Oakla</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerosis</b> <b>442x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive Renal Vascular Disease and 15 yrs</b> DUE TO (c) <b>Myocardial infarction</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 mos</b> <b>3 mos</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-30</b> , 19 <b>57</b> , to <b>1-10</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1-10</b> , 19 <b>58</b> , and that death occurred at <b>11:32 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>R. E. Mance</b>		DATE SIGNED <b>Oakland Md 11/1/58</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Jan. 12, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Bray Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>near Swallow Falls, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Emory Bolden</b>		ADDRESS <b>Oakland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>JAN 15 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

RECEIVED

706

CERTIFICATE OF DEATH

00702

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GRANTSVILLE</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>RURAL GRANTSVILLE</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>CORA</b> First <b>ALICE</b> Middle <b>KAMP</b> Last		4. DATE OF DEATH <b>JAN. 11 1958</b> Month <b>Jan</b> Day <b>11</b> Year <b>1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY. 29 1869</b> 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>GARRETT Co MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>AUSTIN SPEICKER</b>		14. MOTHER'S MAIDEN NAME <b>MARY FRANTZ</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>—</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>NONE</b>	
17. INFORMANT <b>Lloyd Kamp, Grantsville MD</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Chronic Arteriosclerosis</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>10 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 1946</b> to <b>11 Jan 1958</b> , that I last saw the deceased alive on <b>10 Jan 1958</b> , and that death occurred at <b>3 am</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		ADDRESS (Street, city or town, state) <b>Salisbury PA</b> DATE SIGNED <b>13 Jan 58</b>	
PHYSICIAN'S NAME (Type) <b>[Signature]</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>1/13/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>ST. JOHNS LUTHERAN</b>	22d. LOCATION (City, town, or county) (State) <b>ACCIDENT, GARRETT CO MD</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Donald J. Newman, Grantsville Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>JAN 16 '58</b> DATE	24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Faint text]		SEX [Faint text]		AGE [Faint text]		DATE OF BIRTH [Faint text]		PLACE OF BIRTH [Faint text]		RACE [Faint text]		OCCUPATION [Faint text]		CAUSE OF DEATH [Faint text]	
MANNER OF DEATH [Faint text]		PLACE OF DEATH [Faint text]		DATE OF DEATH [Faint text]		TIME OF DEATH [Faint text]		SIGNATURE OF PHYSICIAN [Faint text]		SIGNATURE OF REGISTRAR [Faint text]		SIGNATURE OF WITNESS [Faint text]		SIGNATURE OF DECEASED [Faint text]	
SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]		SIGNATURE OF DECEASED [Faint text]	

BUREAU V. S.

JAN 16 1958

RECEIVED

THIS CERTIFICATE OF DEATH IS A PUBLIC RECORD AND IS NOT TO BE DESTROYED. IT IS THE DUTY OF THE REGISTRAR TO PRESERVE THIS RECORD FOR THE BENEFIT OF THE PUBLIC. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE. THE REGISTRAR IS NOT RESPONSIBLE FOR THE CONTENTS OF THIS CERTIFICATE.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

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707  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Items 2.9 FilmG225 1-30-58 et  
CERTIFICATE OF DEATH

00703

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAKHLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DAKHLAND</b> Arlington 83-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>EVANS NURSING HOME</b>		d. STREET ADDRESS <b>1430 W. Wayne St. (Brother's home)</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>SOPHIE BELLE MIDDLETON</b>		4. DATE OF DEATH Month Day Year <b>JAN. - 17 1958</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUG-27-1873</b>
9. AGE (In years last birthday) <b>84 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>FRANK ELLIOTT MIDDLETON</b>		14. MOTHER'S MAIDEN NAME <b>ELLA CLARK</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>S. CLARK MIDDLETON</b>		Address <b>1430 NORTH WAYNE ST. ARLINGTON VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia</b> <b>480X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Influenza</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Advanced Rheumatoid Arthritis 11 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>2 weeks</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 1957</b> to <b>January 1958</b> , that I last saw the deceased alive on <b>January 16, 1958</b> , and that death occurred at <b>1:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Herbert A. Leighton</b> M.D.		ADDRESS (Street, city or town, state) <b>77 Oak St., Oakland, Md.</b> DATE SIGNED <b>1/17/58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Herbert Leighton</b>		<b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>REMOVAL</b>		22b. DATE THEREOF <b>JAN. 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>OAK HILL</b>		22d. LOCATION (City, town, or county) (State) <b>WASHINGTON D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William</b> ADDRESS <b>OAKLAND MD</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Overman</b>			

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

JAN 22 1938

**BUREAU V. B.**

RECEIVED

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b> <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>STATE ROAD</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>WALTER</b> Middle <b>GREGG</b> Last <b>MYERS</b>		4. DATE OF DEATH Month <b>1</b> Day <b>21</b> Year <b>19 58</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-20-1870</b>
9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
		<b>FRIENDSVILLE, MARYLAND</b>	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>ELIJAH MYERS</b>		14. MOTHER'S MAIDEN NAME <b>SUSAN SISLER</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>UNKNOWN</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
		17. INFORMANT <b>SAMUEL MYERS,</b> Address <b>OAKLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Heart Disease</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arterial Sclerosis</b> (c) <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs.</b> <b>2 yrs.</b> <b>10 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 19, 1958</b> , to <b>January 21, 1958</b> , that I last saw the deceased alive on <b>January 21, 1958</b> , and that death occurred at <b>11:00p M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>22 Jan 58</b>	
PHYSICIAN'S NAME (Type) <b>ANDREW E. MANCE, M.D.</b>		<b>OAKLAND, MARYLAND</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>JAN. 24, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Blooming Rose Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>NEAR Friendsville, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bell &amp; Sons Funeral Home</b>		ADDRESS <b>Oakland Md</b>	
24a. REC'D BY REGISTRAR <b>DATE 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	

BUREAU V. S.

FB 3 1958

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 7 Film G226 2-28-58 et

Reg. Dist. No.

02014

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VA</b> b. COUNTY <b>PRESTON</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TERRA ALTA</b> <b>85x-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>EVANS NURSING HOME - OAKLAND MD</b>		d. STREET ADDRESS <b>210 BRANDONVILLE ST.</b>	
3. NAME OF DECEASED (Type or print) First <b>BENJAMIN</b> Middle <b>PLUM</b> Last <b>PLUM</b>		4. DATE OF DEATH Month <b>JANUARY</b> Day <b>25</b> Year <b>1958</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-4-1880</b>
9. AGE (In years last birthday) <b>77</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>17</b>	IF UNDER 24 HRS. Hours <b>17</b> Min. <b>17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MINE FORMAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL MINES</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOHN C. PLUM</b>		14. MOTHER'S MAIDEN NAME <b>ELLEN GRIMM</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>HERBERT W. PLUM</b>	
17. INFORMANT <b>HERBERT W. PLUM</b>		Address <b>MORGANTOWN, W. VA.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY SCLEROSIS</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>ARTERIOSCLEROSIS</b> DUE TO (c) <b>Mitral Stenosis - Rt. Hypertrophied</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Mitral Stenosis - Rt. Hypertrophied</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>19</b> Hour <b>19</b> o. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>E. I. Baumgartner</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>E. I. BAUMGARTNER</b>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>1/25/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>1-28-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>CAMP GROUNDS CEMETERY</b>		22d. LOCATION (City, town, or county) (State) <b>PRESTON CO. W. VA.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Terra Alta West Virginia</b>		ADDRESS <b>210 BRANDONVILLE ST.</b>	
24a. REC'D BY REGISTRAR <b>FEB 1 8 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. E. Leach</b>	



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

GARRETT COUNTY  
HEALTH DEPT.  
FEB 3 1958

RECEIVED

BUREAU V. 51

FEB 18 1958

RECEIVED

RECEIVED



CERTIFICATE OF DEATH

00705

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>West Virginia</b> b. COUNTY <b>Preston</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Egdon, West Virginia</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <b>Hugh</b> Middle <b>Wilson</b> Last <b>Shaffer</b>		4. DATE OF DEATH Month <b>January</b> Day <b>6</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/15/1895</b>
9. AGE (In years last birthday) <b>62</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>America U.S.A.</b>	
13. FATHER'S NAME <b>Henry Shaffer</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Blamble</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>232-10-6012</b>	
17. INFORMANT <b>Mrs. Charles Teets,</b>		Address <b>Egdon, West Virginia</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardio-renal Disease</b> DUE TO <b>8 years</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/14</b> , 19 <b>57</b> , to <b>1/6</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>1/6</b> , 19 <b>58</b> , and that death occurred at <b>7:00 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Andrew E. Mance</b> M.D.		ADDRESS (Street, city or town, state) <b>Oakland Md</b> DATE SIGNED <b>Jan 58</b>	
PHYSICIAN'S NAME (Type) <b>Dr. Andrew E. Mance</b>		<b>Oakland, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>1/8/58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Texas Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Preston Co. W. Va.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>John D. Duncan, Thomas, P. M.</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE <b>W. H. Smith</b>	

JAN 22 '58

CERTIFICATE OF DEATH

PLACE OF BIRTH (Country)		PLACE OF DEATH (Country)	
PLACE OF BIRTH (City or Town)		PLACE OF DEATH (City or Town)	
DATE OF BIRTH (Month, Day, Year)		DATE OF DEATH (Month, Day, Year)	
SEX Male <input type="checkbox"/> Female <input type="checkbox"/>		SEX Male <input type="checkbox"/> Female <input type="checkbox"/>	
RACE (Specify)		RACE (Specify)	
OCCUPATION (Specify)		OCCUPATION (Specify)	
CAUSE OF DEATH (Specify)		CAUSE OF DEATH (Specify)	
MANNER OF DEATH (Specify)		MANNER OF DEATH (Specify)	
SIGNATURE OF DECEASED (Specify)		SIGNATURE OF DECEASED (Specify)	
SIGNATURE OF WITNESS (Specify)		SIGNATURE OF WITNESS (Specify)	
SIGNATURE OF PHYSICIAN (Specify)		SIGNATURE OF PHYSICIAN (Specify)	
SIGNATURE OF CORONER (Specify)		SIGNATURE OF CORONER (Specify)	
SIGNATURE OF JUDGE (Specify)		SIGNATURE OF JUDGE (Specify)	
SIGNATURE OF CLERK (Specify)		SIGNATURE OF CLERK (Specify)	

BUREAU V. 2

JAN 22 1929

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

711

## CERTIFICATE OF DEATH

Reg. Dist. No. 00706

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>PRESTON</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN lb <b>1 1/2 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KINGWOOD</b> <b>85 x-3</b>			
d. STREET ADDRESS				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>SCHAFER</b> Middle <b>I.</b> Last <b>TROWBRIDGE</b>				4. DATE OF DEATH Month <b>JANUARY</b> Day <b>1</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 1875</b>	9. AGE (In years last birthday) <b>82 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FERRYMAN &amp; FARMER</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME <b>THOMAS TROWBRIDGE</b>			
14. MOTHER'S MAIDEN NAME <b>MARY SCHAFER</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT Address <b>VIOLET DUCKWORTH - CUPPETT'S NURSING HOME, OAKLAND, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>610X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pyelonephritis, Chronic</b> (c) <b>Prostatic Hypertrophy - Operated</b> DUE TO INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>6 months or more</b> <b>Unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Influenza</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Dec 30, 1957</b> , to <b>Jan 1, 1958</b> , that I last saw the deceased alive on <b>Jan 1, 1958</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Herbert H. Leighton</b>				ADDRESS (Street, city or town, State) <b>77 Oak St., Oakland, Md.</b>			
DATE SIGNED <b>Jan 1 1958</b>				PHYSICIAN'S NAME (Type) <b>HERBERT LEIGHTON, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>1/4/1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Kingwood Cemetery, Kingwood, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. H. Browning</b>				ADDRESS <b>Kingwood W. Va.</b>		24a. REC'D BY REGISTRAR DATE <b>JAN 22 58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. H. Brown</b>							

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 712 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

00707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>ALLEGANY</u> b. COUNTY <u>ALLEGANY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE NONE</u>		c. LENGTH OF STAY IN 1b <u>NONE</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND MD. 0102.2</u>		d. STREET ADDRESS <u>1014 ROLLINGMILL ALLEY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>HENRY</u> Last <u>YOUNGER</u>				4. DATE OF DEATH Month <u>JAN</u> Day <u>16</u> Year <u>1958</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 12, 1899</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABOR</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>TRUCKERS HELPER</u>		11. BIRTHPLACE (State or foreign country) <u>DANVILLE, VA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>HENRY YOUNGER</u>				14. MOTHER'S MAIDEN NAME <u>MARY FLIPPEN</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-10-7994</u>		17. INFORMANT <u>Mrs. Walter Younger</u>		Address <u>Cumberland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull</u> 825X DUE TO (b) <u>Fractured Pelvis &amp; Ruptured</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) <u>Abdomen &amp; Evisceration of</u> <u>Abdominal Contents</u> Interval between onset and death <u>Instant</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>TRUCK WRECK, TRUCK PASSED OVER BODY</u>					
20c. TIME OF INJURY Hour <u>7:15</u> o. m. <u>  </u> p. m. <u>  </u> Month, Day, Year <u>1-16-1958</u>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Rt. 40 - Road</u>		20f. (City or town) (County) (State) <u>Nr. Grantsville Garrett Tnd.</u>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>J. H. Feaster Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>J. H. Feaster Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>Jan 18, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Woodlawn Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HAFFER FUNERAL SERVICE, CUMBERLAND MD.</u>				24a. REC'D BY REGISTRAR DATE <u>1958 JAN 16</u>		24b. REGISTRAR'S SIGNATURE <u>  </u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		OCCUPATION	
MANNER OF DEATH		CAUSE OF DEATH		SITE OF LESION		NATURE OF LESION		CHARACTER OF LESION		EXTENT OF LESION	
HISTORY OF CASE		PREVIOUS ILLNESS		TREATMENT		PROGNOSIS		FAMILY HISTORY		SOCIAL HISTORY	
TESTS		X-RAY		LABORATORY		PATHOLOGICAL		CLINICAL		OTHER	
FINDINGS		GROSS		MICROSCOPIC		HISTOCHEMISTRY		IMMUNOLOGY		OTHER	
DISCUSSION		SUMMARY		CONCLUSIONS		REMARKS		SIGNATURE		DATE	

BUREAU V. S.

JAN 20 1938

RECEIVED